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	056291	A. BUILDING _____ B. WING _____	08/09/2008

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	The following reflects the findings of the Department of Public Health during a Complaint Investigation visit. Representing the Department of Public Health: [redacted] CLASS AA CITATION -- PATIENT CARE 95-1313-0005435-F Complaint(s): CA00130756 F 323 483.25 (h)(2) Each resident must receive adequate supervision and assistance devices to prevent accidents. On February 4, 2008, at 8:40 a.m., an unannounced visit was made to the facility to investigate a complaint of alleged gross negligence. Based on interview and record review the licensed nurses and respiratory therapists failed to provide adequate supervision and assistance devices by failing to: 1. Have a system in place to prevent the tracheostomy tube from disconnecting from the ventilator tubing. 2. Monitor that the remote alarm (located directly outside the resident's room on the wall) was on after care was provided. Findings: Resident 1 was a 90 year old female originally admitted to the facility on August 10, 2007 from an acute care hospital on a ventilator, and readmitted to the facility on October 22, 2007, on the sub-acute unit (which provides a higher level of nursing care) with diagnoses that included, respiratory			

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	Continued From page 1 failure and ventilator dependency, chronic obstructive pulmonary disease, atrial fibrillation, congestive heart failure and severe aortic stenosis. The respiratory admission orders dated October 22, 2007, indicated the resident was to be on a ventilator and the ventilator was to deliver the following: Tidal volume (air breathed in and out of the airway during the normal breathing process) of 600 cubic centimeter (cc), 5 liters of oxygen and a respiratory rate of 10 and the mode of assist/control. According to Egan's Fundamentals of Respiratory Care Ninth Edition page 1053 assist/control means every breath is supported by the ventilator. Breaths are patient or time triggered to inspiration and may be volume or pressure limited. The physician's order dated October 25, 2007, indicated the resident's ventilator setting mode was to be changed to synchronized intermittent mandatory ventilation (SIMV) of 8 breaths as tolerated. According to Egan's Fundamentals of Respiratory Care Ninth Edition page 993, SIMV of 8 means, the resident is allowed to breathe on her own and the resident would have 8 mandatory breaths per minute from the ventilator, but the ventilator would synchronize the machine breaths and the resident's own breaths. The care plan dated October 2007, (the specific date was illegible) indicated the resident was at risk for becoming disconnected from the ventilator due to coughing, and the plan was to check the ventilator alarms. The plan of care did not address			

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	Continued From page 2 the frequency of monitoring the ventilator alarms. There was no evidence presented or in the clinical record that the facility provided a device to prevent the resident's tracheostomy tube from disconnecting from the ventilator tubing. A review of the licensed nurses notes, respiratory notes and the ventilator monitoring records dated October 25, 2007 to October 27, 2007, revealed there was no evidence to demonstrate that the licensed nurses or respiratory therapists were checking if the ventilator alarms were activated and that the remote alarm was on. According to Employee 12 there was no policy in place prior to the resident's death regarding the remote ventilator alarms usage. According to the Remote Ventilator Alarms Connecting and Usage Policy and Procedure allows the caregiver to see and hear the alarms up to 200 feet from the ventilator. On February 4, 2008, at 9:40 a.m., the evaluator asked Employee 5 to try to recreate the situation by turning off the remote alarm to see if the ventilator alarm alone could be heard outside of the room. Employee 5 found a resident on the same type of ventilator Resident 1 was using when she expired. The evaluator was standing outside the door (approximately 10 feet) and could barely hear the ventilator alarm. According to a letter addressed to the evaluator dated August 20, 2008, from technician who is employed by the ventilator company that rents the ventilators to the facility, the alarm volume on the ventilator cannot be			

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	Continued From page 3 adjusted, only silenced. When the remote/accessory alarm outside of the room was turned back on, it was a loud high-pitched sound in beeps of two that could be heard all the way down the hallway past the nurse's station. The distance from the patient's room to the nurse's station was approximately 50 feet. During an interview on June 5, 2008, at 12:00 p.m., Employee 11 stated the remote alarm is turned off when the staff provides care for the resident, but should be turned back on before leaving the resident alone. However, when requested the facility representative was unable to provide a policy that existed at the time of the event, to confirm this process. A review of the licensed nurses note written by Employee 3 dated on October 27, 2007, at 5:15 p.m. indicated the nurse gave the resident her medication, she was asleep and in no distress. At 5:30 p.m., Employee 4's nurses note revealed the resident's tracheostomy tube was intact. At 5:35 p.m., the note indicated the tracheostomy tube was connected to the ventilator. The licensed nurses note written by Employee 4 also indicated, at 6:02 p.m., the resident's family member returned to the facility and found the resident disconnected from the ventilator and asked how long the resident had been disconnected from the ventilator. The licensed nurses note further revealed the respiratory therapists and licensed staff rushed to the bedside and called 911. The resident was unresponsive and she was in full code			

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	Continued From page 4 status. At 6:30 p.m., the paramedics pronounced the resident dead, according to the licensed nurses note written by Employee 4. A written statement from Employee 3 provided by Employee 12 dated October 27, 2007, indicated at 6:00 p.m., she noticed the commotion in Resident 1's room. She immediately went to the room and noticed Employee 1 bagging (manually squeezing air through a tube that has been inserted in a persons mouth, the tube goes through the trachea down into the lungs) the resident and Employee 9 was connecting the Ambu bag to the oxygen tank. She noticed the resident was unresponsive and cyanotic (bluish discoloration of the skin caused by inadequate oxygenation of the blood) around her lips and fingertips. Employee 3 proceeded to check the resident for a pulse. There was no pulse, so she initiated chest compressions and asked one of the certified nursing assistants to get a backboard. At that time Employee 3 asked had anyone called 911. Employee 1 relieved her and started doing chest compressions and alternated with Employee 9. Employee 9 was suctioning the resident orally and tracheal suctioning. At 6:10 p.m., the paramedics arrived, the continued cardiopulmonary resuscitation (CPR). At 6:30 p.m., the paramedics pronounced the resident dead. The Ventilator Monitor Record dated October 27, 2007, indicated Employee 1 checked the ventilator at 8:20 a.m., 9:50 a.m., 3:50 p.m. and 5:05 p.m. There was no documentation that the remote alarm was checked to ensure it was on.			

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	Continued From page 5 According to the Respiratory Therapy Progress Notes written by Employee 1 dated October 27, 2007, at 6:00 p.m., the resident was found unresponsive. There was no mention of the resident being found disconnected from the ventilator as indicated in Employee 1's interview with the evaluator. The progress note did not address whether the remote alarm or the ventilator alarms were checked. During an interview on February 4, 2008, at 9:30 a.m., Employee 5 said the ventilators are checked every six hours according to their policy, unless there is something wrong with the resident then they check the ventilator as needed. However, there was no documentation to show the remote alarm was checked. The evaluator obtained a copy of the policy Employee 5 referred to, but the policy was not dated. On February 5, 2008, the ventilator technician, who is employed by the ventilator company that rents the ventilators to the facility, downloaded the information from the computer within the ventilator that Resident 1 was using when she expired. According to the technician's review and interpretation of the printout the following events took place on October 27, 2007 around the time the resident expired: □ 3:36 p.m., the change of pressure alarm was activated. □ 3:38 p.m., the remote alarm (the alarm outside of the room on the wall that coincides with the alarm on the ventilator) was silenced and turned off. □ 4:50 p.m., the inspiration alert was activated and			

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	Continued From page 6 remained activated until 5:27 p.m. □ 5:27 p.m., the remote alarm was turned back on and silenced. Also, at that time the change of setting alarm was activated. □ 6:19 p.m., the remote alarm was silenced. According to a letter from the ventilator technician (addressed to the evaluator) he added one hour to the times because of daylight savings time. The ventilator technician also stated the conditions that may cause the inspiration alert alarm to activate are coughing, and the patient becoming disconnected from the ventilator or death. The change of pressure alarm indicated there is a change in pressure of the air being delivered to the patient, either too high, too low or no resistance. The change of setting alarm sounds when someone changes the settings on the ventilator. The remote alarm is an accessory alarm connected to the ventilator located outside the room on the wall. The down loaded information indicated the inspiration alert alarm was activated and remained activated for 37 minutes from 4:50 p.m. to 5:27 p.m. One half an hour later the family member found the resident disconnected from the ventilator and unresponsive. On February 7, 2008, at 10:05 a.m., during a telephone interview, Employee 1 stated he was unaware of the care plan written by Employee 2 that indicated the resident was at risk for becoming disconnected from the ventilator due to coughing related to congestion. He indicated the alarm on the resident's ventilator was activated often and that he had other patients and could not check on			

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	Continued From page 7 Resident 1 "every 5 minutes". Employee 1 went on to say the facility's policy indicated they were to check the ventilator every 6 hours, but he checked it more than every 6 hours but did not document it. The evaluator obtained a copy of the policy Employee 1 was referring to, but it was not dated. There was no discussion regarding checking the alarm and nothing in the clinical record that addressed that the remote alarm was monitored. Employee 1 stated he was at the nurse's station when Resident 1's family member yelled for help. He did not hear the alarms. When he got to the resident's room he noticed the resident was disconnected from the ventilator and unresponsive. He went on to say he reconnected the resident to the ventilator. Someone brought in the crash cart and he and the licensed nurses initiated cardiopulmonary resuscitation, but the resident expired. On February 21, 2008, at 9:45 a.m., an interview with the resident's family member revealed she visited Resident 1 at the same time everyday for several weeks and had not seen the nurses or respiratory therapists check the alarms. The Family Member went on to say on many occasions she visited the resident and discovered the remote alarm had been turned off, and reported it to Employee 2. On October 27, 2007 she left the facility to pick up her father at 5 p.m., and returned at 6 p.m., the same routine everyday. When she returned, she noticed the resident was disconnected from the ventilator, unresponsive and that the remote alarm was not sounding. She yelled for help and Employee 1 was the first to respond.			

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	Continued From page 8 According to the Family Member, Employee 1 checked the resident and told the Family Member to get him an oxygen tank. The Family Member stated she yelled to the nurses to get oxygen. After that, the staff was running around like they did not know what to do. During an interview on June 5, 2008, at 10:30 a.m., Employee 2 stated the day the resident expired she was off duty but received a call at home from the facility, but could not remember who called. The caller told her Resident 1 expired and the alarm on the machine was on but it did not sound. She stated when she came back to work the ventilator was still in the resident's room, she checked the ventilator alarm and it was working. Employee 2 went on to say when Resident 1 expired there was no policy in place regarding the alarms. The Remote Ventilator Alarms Connecting and Usage Policy was created on December 24, 2007, after the resident expired. The facility failed to: 1. Have a system in place to prevent Resident 1's tracheostomy tube from disconnecting from the ventilator tubing, which was a direct proximate cause of the resident's death. 2. Monitor that the remote alarm (located directly outside the resident's room on the wall) was on after care was provided. The above violations jointly, separately or in any combination presented either an imminent danger that death or serious harm would result or substantial probability that death or serious			

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	Continued From page 9 physical harm would result and was a direct proximate cause of death to Resident 1.			

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